HEALTH REFORM AMENDMENTS

2014 GENERAL SESSION

STATE OF UTAH

LONG TITLE

General Description:

This bill amends provisions related health insurance and state and federal health care reform.

Highlighted Provisions:

This bill:

- amends the period of time in which an employee of a state contractor must be enrolled in health insurance to conform to federal law;
- amends the health insurance navigator license chapter of the Insurance Code to:
  - create two types of navigator license;
  - establish different training for the types of license; and
  - add an exception to the license requirement for Indian health centers;
- amends the state Comprehensive Health Insurance Pool to:
  - close the pool to new enrollees;
  - pay out claims incurred by enrollees prior to January 1, 2014;
  - close down the business of the pool; and
  - beginning July 1, 2015, transfer funds remaining in the pool's enterprise fund into the Small Employer Rebate Program Enterprise Fund;
- creates the Individual and Small Employer Risk Adjustment Act which:
  - requires the insurance commissioner to work with stakeholders to develop a state based risk adjustment program for the individual and small group market;
  - describes the risk adjustment models the commissioner may consider;
  - requires the commissioner to report to the Legislature before implementing a risk adjustment model;
  - authorizes the commissioner to set fees for the operation of the risk adjustment program; and
  - establishes an Individual and Small Employer Risk Adjustment Enterprise Fund for the operation of the program;

- ▸ establishes the Small Employer Premium Rebate Program which:
  - defines terms;
  - establishes the rebate program for taxable years 2014 through 2017;
  - requires the insurance commissioner to establish a formula to calculate each year's premium rebate; and
  - creates the Small Employer Rebate Enterprise Fund;
- ▸ requires the Office of Consumer Health Services, which runs the small employer health insurance exchange, to submit the form required for the federal small employer premium tax credit to the Internal Revenue Service;
- ▸ re-authorizes the Health Care Compact until July 1, 2019;
- ▸ repeals certain provisions of the Comprehensive Health Insurance Pool; and
- ▸ makes technical and conforming amendments.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

17B-2a-818.5, as last amended by Laws of Utah 2012, Chapter 347

19-1-206, as last amended by Laws of Utah 2012, Chapter 347

31A-23b-205, as enacted by Laws of Utah 2013, Chapter 341

31A-23b-206, as enacted by Laws of Utah 2013, Chapter 341

31A-23b-211, as enacted by Laws of Utah 2013, Chapter 341

31A-29-106, as last amended by Laws of Utah 2013, Chapter 319

31A-29-110, as last amended by Laws of Utah 2012, Chapter 347

31A-29-113, as last amended by Laws of Utah 2013, Chapter 319

31A-29-114, as last amended by Laws of Utah 2006, Chapter 95

31A-29-120, as last amended by Laws of Utah 2003, Chapter 168

31A-30-103, as last amended by Laws of Utah 2013, Chapter 168

31A-30-108, as last amended by Laws of Utah 2011, Chapter 284

63A-5-205, as last amended by Laws of Utah 2012, Chapter 347

63C-9-403, as last amended by Laws of Utah 2012, Chapter 347
63I-1-231 (Effective 07/01/14), as last amended by Laws of Utah 2013, Chapters 261 and 417
63I-1-263, as last amended by Laws of Utah 2013, Chapters 28, 62, 101, 167, 250, and 413
63M-1-2504, as last amended by Laws of Utah 2013, Chapter 255
63M-1-2507, as enacted by Laws of Utah 2012, Chapter 206
72-6-107.5, as last amended by Laws of Utah 2012, Chapter 347
79-2-404, as last amended by Laws of Utah 2012, Chapter 347

ENACTS:

31A-23b-202.5, Utah Code Annotated 1953
31A-30-301, Utah Code Annotated 1953
31A-30-302, Utah Code Annotated 1953
31A-30-303, Utah Code Annotated 1953
31A-30-401, Utah Code Annotated 1953
31A-30-402, Utah Code Annotated 1953
31A-30-403, Utah Code Annotated 1953
31A-30-404, Utah Code Annotated 1953
31A-30-405, Utah Code Annotated 1953

REPEALS:

31A-29-111, as last amended by Laws of Utah 2012, Chapters 158 and 347
31A-29-112, as last amended by Laws of Utah 2012, Chapter 253
31A-29-115, as last amended by Laws of Utah 2004, Chapter 2
31A-29-116, as last amended by Laws of Utah 2008, Chapter 382
31A-29-117, as last amended by Laws of Utah 2007, Chapter 40

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **17B-2a-818.5** is amended to read:

17B-2a-818.5. Contracting powers of public transit districts -- Health insurance coverage.

(1) For purposes of this section:

(a) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of hire.

(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

(c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) (a) Except as provided in Subsection (3), this section applies to a design or construction contract entered into by the public transit district on or after July 1, 2009, and to a prime contractor or to a subcontractor in accordance with Subsection (2)(b).

(b) (i) A prime contractor is subject to this section if the prime contract is in the amount of $1,500,000 or greater.

(ii) A subcontractor is subject to this section if a subcontract is in the amount of $750,000 or greater.

(3) This section does not apply if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section 63G-6a-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

(b) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (2) is guilty of an infraction.

(5) (a) A contractor subject to Subsection (2) shall demonstrate to the public transit district that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employee's dependents during the duration of the contract.

(b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor

shall demonstrate to the public transit district that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employee's dependents during the duration of the contract.

(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with an ordinance adopted by the public transit district under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during the duration of the contract is subject to penalties in accordance with an ordinance adopted by the public transit district under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (5)(a).

(6) The public transit district shall adopt ordinances:

(a) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) the State Building Board in accordance with Section 63A-5-205;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403; and

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(b) which establish:

(i) the requirements and procedures a contractor shall follow to demonstrate to the public transit district compliance with this section which shall include:

(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or (b) more than twice in any 12-month period; and

(B) that the actuarially equivalent determination required for the qualified health insurance coverage in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(I) the Utah Insurance Department;

(II) an actuary selected by the contractor or the contractor's insurer; or

(III) an underwriter who is responsible for developing the employer group's premium

rates;

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the public transit district upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the public transit district upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for employees and dependents of employees of the contractor or subcontractor who were not offered qualified health insurance coverage during the duration of the contract; and

(iii) a website on which the district shall post the benchmark for the qualified health insurance coverage identified in Subsection (1)(c).

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(b)(ii), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if:

(A) the employer relied in good faith on a written statement of actuarial equivalency provided by an:

(I) actuary; or

(II) underwriter who is responsible for developing the employer group's premium rates; or

(B) a department or division determines that compliance with this section is not required under the provisions of Subsection (3) or (4).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the

Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 2. Section **19-1-206** is amended to read:

19-1-206. Contracting powers of department -- Health insurance coverage.

(1) For purposes of this section:

(a) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of hire.

(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

(c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) (a) Except as provided in Subsection (3), this section applies to a design or construction contract entered into by or delegated to the department or a division or board of the department on or after July 1, 2009, and to a prime contractor or subcontractor in accordance with Subsection (2)(b).

(b) (i) A prime contractor is subject to this section if the prime contract is in the amount of $1,500,000 or greater.

(ii) A subcontractor is subject to this section if a subcontract is in the amount of $750,000 or greater.

(3) This section does not apply to contracts entered into by the department or a division or board of the department if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract or agreement is between:

(i) the department or a division or board of the department; and

(ii) (A) another agency of the state;

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state;

(c) the executive director determines that applying the requirements of this section to a particular contract interferes with the effective response to an immediate health and safety threat from the environment; or

(d) the contract is:

(i) a sole source contract; or

(ii) an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section 63G-6a-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

(b) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (2) is guilty of an infraction.

(5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive director that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents during the duration of the contract.

(b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall demonstrate to the executive director that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the contract.

(c) (i) (A) A contractor who fails to comply with Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) a public transit district in accordance with Section 17B-2a-818.5;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) the State Building Board in accordance with Section 63A-5-205;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) which establish:

(i) the requirements and procedures a contractor shall follow to demonstrate to the public transit district compliance with this section that shall include:

(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or (b) more than twice in any 12-month period; and

(B) that the actuarially equivalent determination required for the qualified health insurance coverage in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(I) the Utah Insurance Department;

(II) an actuary selected by the contractor or the contractor's insurer; or

(III) an underwriter who is responsible for developing the employer group's premium rates;

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into

future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(D) notwithstanding Section 19-1-303, monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and the dependents of an employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract; and

(iii) a website on which the department shall post the benchmark for the qualified health insurance coverage identified in Subsection (1)(c).

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if:

(A) the employer relied in good faith on a written statement of actuarial equivalency provided by:

(I) an actuary; or

(II) an underwriter who is responsible for developing the employer group's premium rates; or

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3) or (4).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror,

or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 3. Section **31A-23b-202.5** is enacted to read:

31A-23b-202.5. License types.

(1) A license issued under this chapter shall be issued under the license types described in Subsection (2).

(2) A license type under this chapter shall be a navigator line of authority or a certified application counselor line of authority. A license type is intended to describe the matters to be considered under any education, examination and training required of an applicant under this chapter.

(3) (a) A navigator line of authority includes the enrollment process as described in Subsection 31A-23b-102(4)(a).

(b) (i) A certified application counselor line of authority is limited to providing information and assistance to individuals and employees about public programs and premium subsidies available through the exchange.

(ii) A certified application counselor line of authority does not allow the certified application counselor to assist a person with the selection of or enrollment in a qualified health plan offered on an exchange.

Section 4. Section **31A-23b-205** is amended to read:

31A-23b-205. Examination and training requirements.

(1) The commissioner may require [~~applicants~~] an applicant for a license to pass an examination and complete a training program as a requirement for a license.

(2) The examination described in Subsection (1) shall reasonably relate to:

(a) the duties and functions of a navigator;

(b) requirements for navigators as established by federal regulation under PPACA; and

(c) other requirements that may be established by the commissioner by administrative rule.

(3) The examination may be administered by the commissioner or as otherwise

specified by administrative rule.

(4) The training required by Subsection (1) shall be approved by the commissioner and shall include:

(a) accident and health insurance plans;

(b) qualifications for and enrollment in public programs;

(c) qualifications for and enrollment in premium subsidies;

(d) cultural and linguistic competence;

(e) conflict of interest standards;

(f) exchange functions; and

(g) other requirements that may be adopted by the commissioner by administrative rule.

(5) (a) For the navigator line of authority, the training required by Subsection (1) shall consist of:

(i) at least 21 credit hours of training before obtaining the license;

(ii) at least two of the 21 hours described in Subsection (5)(a)(i) be training on defined contribution arrangements and the small employer health insurance exchange; and

(iii) the navigator training and certification program developed by the Centers for Medicare and Medicaid Services.

(b) For the certified application counselor line of authority, the training required by Subsection (1) shall consist of:

(i) at least six hours of training before obtaining a license;

(ii) at least one of the six described in Subsection (5)(b)(i) be training on defined contribution arrangements and the small employer health insurance exchange; and

(iii) the certified application counselor training and certification program developed by the Centers for Medicare and Medicaid Services.

[~~(5)~~] (6) This section applies only to [~~applicants who are natural persons~~] an applicant who is a natural person.

Section 5. Section **31A-23b-206** is amended to read:

31A-23b-206. Continuing education requirements.

(1) The commissioner shall, by rule, prescribe continuing education requirements for a navigator.

(2) (a) The commissioner may not require a degree from an institution of higher education as part of continuing education.

(b) The commissioner may state a continuing education requirement in terms of hours of instruction received in:

(i) accident and health insurance;

(ii) qualification for and enrollment in public programs;

(iii) qualification for and enrollment in premium subsidies;

(iv) cultural competency;

(v) conflict of interest standards; and

(vi) other exchange functions.

(3) (a) [~~Continuing~~] For a navigator line of authority, continuing education requirements shall require:

(i) that a licensee complete [~~24~~] 12 credit hours of continuing education for every [~~two-year~~] one-year licensing period;

(ii) that [~~3~~] at least two of the [~~24~~] 12 credit hours described in Subsection (3)(a)(i) be ethics courses; [~~and~~]

[~~(iii) that the licensee complete at least half of the required hours through classroom hours of insurance and exchange related instruction.~~]

(iii) that at least one of the 12 credit hours described in Subsection (3)(a)(i) be training on defined contribution arrangements and the use of the small employer health insurance exchange; and

(iv) that a licensee complete the annual navigator training and certification program developed by the Centers for Medicare and Medicaid Services.

(b) For a certified application counselor, the continuing education requirements shall require:

(i) that a licensee complete six credit hours of continuing education for every one- year licensing period;

(ii) that at least two of the six credit hours described in Subsection (3)(b)(i) be on ethics;

(iii) that at least one of the six credit hours described in Subsection (3)(b)(i) be training on defined contribution arrangements and the use of the small employer health insurance

exchange; and

(iv) that a licensee complete the annual certified application counselor training and certification program developed by the Centers for Medicare and Medicaid Services.

[~~(b)~~] (c) An hour of continuing education in accordance with [~~Subsection~~] Subsections (3)(a)(i) and (3)(b)(i) may be obtained through:

(i) classroom attendance;

(ii) home study;

(iii) watching a video recording; or

[~~(iv) experience credit; or~~]

[~~(v)~~] (iv) another method approved by rule.

[~~(c)~~] (d) A licensee may obtain continuing education hours at any time during the [~~two-year~~] one-year license period.

[~~(d)~~] (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall, by rule[~~: (i) publish a list of insurance professional designations whose continuing education requirements can be used to meet the requirements for continuing education under Subsection (3)(b); and (ii)~~] authorize one or more continuing education providers, including a state or national professional producer or consultant associations, to:

[~~(A)~~] (i) offer a qualified program on a geographically accessible basis; and

[~~(B)~~] (ii) collect a reasonable fee for funding and administration of a continuing education program, subject to the review and approval of the commissioner.

(4) The commissioner shall approve a continuing education provider or a continuing education course that satisfies the requirements of this section.

(5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall by rule establish the procedures for continuing education provider registration and course approval.

(6) This section applies only to a navigator who is a natural person.

(7) A navigator shall keep documentation of completing the continuing education requirements of this section for two years after the end of the two-year licensing period to which the continuing education applies.

Section 6. Section **31A-23b-211** is amended to read:

31A-23b-211. Exceptions to navigator licensing.

(1) For purposes of this section:

(a) "Negotiate" is as defined in Section 31A-23a-102.

(b) "Sell" is as defined in Section 31A-23a-102.

(c) "Solicit" is as defined in Section 31A-23a-102.

(2) The commissioner may not require a license as a navigator of:

(a) a person who is employed by or contracts with:

(i) a health care facility that is licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act, to assist an individual with enrollment in a public program or an application for premium subsidy; or

(ii) the state, a political subdivision of the state, an entity of a political subdivision of the state, or a public school district to assist an individual with enrollment in a public program or an application for premium subsidy;

(b) a federally qualified health center as defined by Section 1905(1)(2)(B) of the Social Security Act which assists an individual with enrollment in a public program or an application for premium subsidy;

(c) a person licensed under Chapter 23a, Insurance Marketing-Licensing, Consultants, and Reinsurance Intermediaries, if the person is licensed in the appropriate line of authority to sell, solicit, or negotiate accident and health insurance plans;

(d) an officer, director, or employee of a navigator:

(i) who does not receive compensation or commission from an insurer issuing an insurance contract, an agency administering a public program, an individual who enrolled in a public program or insurance product, or an exchange; and

(ii) whose activities:

(A) are executive, administrative, managerial, clerical, or a combination thereof;

(B) only indirectly relate to the sale, solicitation, or negotiation of insurance, or the enrollment in a public program offered through the exchange;

(C) are in the capacity of a special agent or agency supervisor assisting an insurance producer or navigator;

(D) are limited to providing technical advice and assistance to a licensed insurance producer or navigator; or

(E) do not include the sale, solicitation, or negotiation of insurance, or the enrollment

in a public program; [~~and~~]

(e) a person who does not sell, solicit, or negotiate insurance and is not directly or indirectly compensated by an insurer issuing an insurance contract, an agency administering a public program, an individual who enrolled in a public program or insurance product, or an exchange, including:

(i) an employer, association, officer, director, employee, or trustee of an employee trust plan who is engaged in the administration or operation of a program:

(A) of employee benefits for the employer's or association's own employees or the employees of a subsidiary or affiliate of an employer or association; and

(B) that involves the use of insurance issued by an insurer or enrollment in a public health plan on an exchange;

(ii) an employee of an insurer or organization employed by an insurer who is engaging in the inspection, rating, or classification of risk, or the supervision of training of insurance producers; or

(iii) an employee who counsels or advises the employee's employer with regard to the insurance interests of the employer, or a subsidiary or business affiliate of the employer[~~.~~]; and

(f) an Indian health clinic or Urban Indian Health Center, as defined in Title V of the Indian Health Care Improvement Act, which assists a person with enrollment in a public program or an application for a premium subsidy.

(3) The exemption from licensure under Subsections (2)(a) [~~and~~], (b), and (f) does not apply if a person described in Subsections (2)(a) [~~and~~], (b), and (f) enrolls a person in a private insurance plan.

(4) The commissioner may by rule exempt a class of persons from the license requirement of Subsection 31A-23b-201(1) if:

(a) the functions performed by the class of persons do not require:

(i) special competence;

(ii) special trustworthiness; or

(iii) regulatory surveillance made possible by licensing; or

(b) other existing safeguards make regulation unnecessary.

Section 7. Section **31A-29-106** is amended to read:

31A-29-106. Powers of board.

(1) The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health care insurance business. In addition, the board shall [~~have the specific authority to~~]:

(a) have the specific authority to enter into contracts to carry out the provisions and purposes of this chapter, including, with the approval of the commissioner, contracts with:

(i) similar pools of other states for the joint performance of common administrative functions; or

(ii) persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking such legal action necessary to avoid the payment of improper claims against the pool or the coverage provided through the pool;

(c) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the pool;

[~~(d) issue policies of insurance in accordance with the requirements of this chapter;~~]

(d) (i) effective January 1, 2014, close enrollment in the plans issued by the pool and cancel the plans issued by the pool; and

(ii) close out the business of the pool in accordance with the plan of operation adopted by the board under Section 31A-29-105, including processing and paying valid claims incurred by enrollees prior to January 1, 2014;

(e) retain an executive director and appropriate legal, actuarial, and other personnel as necessary to provide technical assistance in the operations of the pool and to close pool business in accordance with Subsection (1)(d);

(f) establish rules, conditions, and procedures for reinsuring risks under this chapter;

(g) cause the pool to have an annual and a final audit of its operations by the state auditor;

[~~(h) coordinate with the Department of Health in seeking to obtain from the Centers for Medicare and Medicaid Services, or other appropriate office or agency of government, all appropriate waivers, authority, and permission needed to coordinate the coverage available from the pool with coverage available under Medicaid, either before or after Medicaid coverage, or as a conversion option upon completion of Medicaid eligibility, without the necessity for requalification by the enrollee;~~]

[~~(i)~~] (h) provide for and employ cost containment measures and requirements including preadmission certification, concurrent inpatient review, and individual case management for the purpose of making the pool more cost-effective;

[~~(j) offer pool coverage through contracts with health maintenance organizations;~~] preferred provider organizations, and other managed care systems that will manage costs while maintaining quality care;

[~~(k)~~] (i) establish annual limits on benefits payable under the pool to or on behalf of any enrollee;

[~~(l)~~] (j) exclude from coverage under the pool specific benefits, medical conditions, and procedures for the purpose of protecting the financial viability of the pool;

[~~(m)~~] (k) administer the Pool Fund;

[~~(n)~~] (l) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this chapter;

[~~(o)~~] (m) adopt, trademark, and copyright a trade name for the pool for use in marketing and publicizing the pool and its products; and

[~~(p)~~] (n) transition health care coverage for all individuals covered under the pool as part of the conversion to health insurance coverage, regardless of preexisting conditions, under PPACA.

(2) (a) The board shall prepare and submit an annual and final report to the Legislature which shall include:

(i) the net premiums anticipated;

(ii) actuarial projections of payments required of the pool;

(iii) the expenses of administration; and

(iv) the anticipated reserves or losses of the pool.

(b) The budget for operation of the pool is subject to the approval of the board.

(c) The administrative budget of the board and the commissioner under this chapter shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is subject to review and approval by the Legislature.

[~~(3) (a) The board shall on or before September 1, 2004, require the plan administrator or an independent actuarial consultant retained by the plan administrator to redetermine the reasonable equivalent of the criteria for uninsurability required under Subsection~~

~~31A-30-106(1)(h) that is used by the board to determine eligibility for coverage in the pool.~~]

[~~(b) The board shall redetermine the criteria established in Subsection (3)(a) at least every five years thereafter.~~]

(3) Rules promulgated by the commissioner shall continue in force until modified by the commissioner or until superseded by a subsequent plan of operation submitted by the board and approved by the commissioner.

(4) The commissioner may designate an executive secretary from the department to provide administrative assistance to the board in carrying out its responsibilities.

Section 8. Section **31A-29-110** is amended to read:

31A-29-110. Pool administrator -- Selection -- Powers.

(1) The board shall select a pool administrator in accordance with Title 63G, Chapter 6a, Utah Procurement Code. The board shall evaluate bids based on criteria established by the board, which shall include:

(a) ability to manage medical expenses;

(b) proven ability to handle accident and health insurance;

(c) efficiency of claim paying procedures;

(d) marketing and underwriting;

(e) proven ability for managed care and quality assurance;

(f) provider contracting and discounts;

(g) pharmacy benefit management;

(h) an estimate of total charges for administering the pool; and

(i) ability to administer the pool in a cost-efficient manner.

(2) A pool administrator may be:

(a) a health insurer;

(b) a health maintenance organization;

(c) a third-party administrator; or

(d) any person or entity which has demonstrated ability to meet the criteria in Subsection (1).

(3) [~~(a)~~] The pool administrator shall serve for a period of three years, with [~~two one-year~~] yearly extension options until the operations of the pool are closed pursuant to Subsection 31A-29-106(1)(d), subject to the terms, conditions, and limitations of the contract

between the board and the administrator.

[~~(b) At least one year prior to the expiration of the contract between the board and the pool administrator, the board shall invite all interested parties, including the current pool administrator, to submit bids to serve as the pool administrator~~].

[~~(c) Selection of the pool administrator for a succeeding period shall be made at least six months prior to the expiration of the period of service under Subsection (3)(a).~~]

(4) The pool administrator is responsible for all operational functions of the pool and shall:

(a) have access to all nonpatient specific experience data, statistics, treatment criteria, and guidelines compiled or adopted by the Medicaid program, the Public Employees Health Plan, the Department of Health, or the Insurance Department, and which are not otherwise declared by statute to be confidential;

(b) perform all marketing, eligibility, enrollment, member agreements, and administrative claim payment functions relating to the pool;

(c) establish, administer, and operate a monthly premium billing procedure for collection of premiums from enrollees;

(d) perform all necessary functions to assure timely payment of benefits to enrollees, including:

(i) making information available relating to the proper manner of submitting a claim for benefits to the pool administrator and distributing forms upon which submission shall be made; and

(ii) evaluating the eligibility of each claim for payment by the pool;

(e) submit regular reports to the board regarding the operation of the pool, the frequency, content, and form of which reports shall be determined by the board;

(f) following the close of each calendar year, determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and submit a report of this information to the board, the commissioner, and the Division of Finance on a form prescribed by the commissioner; and

(g) be paid as provided in the plan of operation for expenses incurred in the performance of the pool administrator's services.

Section 9. Section **31A-29-113** is amended to read:

31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting conditions -- Waiver -- Maximum benefits.

(1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished for the diagnoses or treatment of illness or injury that:

(i) exceed the deductible and copayment amounts applicable under Section 31A-29-114; and

(ii) are not otherwise limited or excluded.

(b) Eligible medical expenses are the allowed charges established by the board for the health care services and items rendered during times for which benefits are extended under the pool policy.

(c) Section 31A-21-313 applies to coverage issued under this chapter.

(2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and other limitations shall be established by the board.

(3) The commissioner shall approve the benefit package developed by the board to ensure its compliance with this chapter.

(4) The pool shall offer at least one benefit plan through a managed care program as authorized under Section 31A-29-106.

(5) This chapter may not be construed to prohibit the pool from issuing additional types of pool policies with different types of benefits which in the opinion of the board may be of benefit to the citizens of Utah.

(6) (a) The board shall design and require an administrator to employ cost containment measures and requirements including preadmission certification and concurrent inpatient review for the purpose of making the pool more cost effective.

(b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this chapter.

(7) (a) A pool policy may contain provisions under which coverage for a preexisting condition is excluded if:

(i) the exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received, from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law, within the six-month period

ending on the effective date of plan coverage; and

(ii) except as provided in Subsection (8), the exclusion extends for a period no longer than the six-month period following the effective date of plan coverage for a given individual.

(b) Subsection (7)(a) does not apply to a HIPAA eligible individual.

(8) (a) A pool policy may contain provisions under which coverage for a preexisting pregnancy is excluded during a ten-month period following the effective date of plan coverage for a given individual.

(b) Subsection (8)(a) does not apply to a HIPAA eligible individual.

(9) (a) The pool will waive the preexisting condition exclusion described in Subsections (7)(a) and (8)(a) for an individual that is changing health coverage to the pool, to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if the individual applies not later than 63 days following the date of involuntary termination, other than for nonpayment of premiums, from health coverage.

(b) If this Subsection (9) applies, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

(10) Covered benefits available from the pool may not exceed a $1,800,000 lifetime maximum, which includes a per enrollee calendar year maximum established by the board.

Section 10. Section **31A-29-114** is amended to read:

31A-29-114. Deductibles -- Copayments.

(1) (a) A pool policy shall impose a deductible on a per calendar year basis.

(b) At least two deductible plans shall be offered.

(c) The deductible is applied to all of the eligible medical expenses [~~as defined in Section 31A-29-113,~~] incurred by the enrollee until the deductible has been satisfied. There are no benefits payable before the deductible has been satisfied.

(d) The pool may offer separate deductibles for prescription benefits.

(2) (a) A mandatory coinsurance requirement shall be imposed at the rate of at least 20%, except for a qualified high deductible health plan, of eligible medical expenses in excess of the mandatory deductible.

(b) Any coinsurance imposed under this Subsection (2) shall be designated in the pool policy.

(3) The board shall establish maximum aggregate out-of-pocket payments for eligible

medical expenses incurred by the enrollee for each of the deductible plans offered under Subsection (1)(b).

(4) (a) When the enrollee has incurred the maximum aggregate out-of-pocket payments under Subsection (3), the board may establish a coinsurance requirement to be imposed on eligible medical expenses in excess of the maximum aggregate out-of-pocket expense.

(b) The circumstances in which the coinsurance authorized by this Subsection (4) may be imposed shall be designated in the pool policy.

(c) The coinsurance authorized by this Subsection (4) may be imposed at a rate not to exceed 5% of eligible medical expenses.

(5) The limits on maximum aggregate out-of-pocket payments for eligible medical expenses incurred by the enrollee under this section may not include out-of-pocket payments for prescription benefits.

Section 11. Section **31A-29-120** is amended to read:

31A-29-120. Enterprise fund.

(1) There is created an enterprise fund known as the Comprehensive Health Insurance Pool Enterprise Fund.

(2) The following funds shall be credited to the pool fund:

(a) appropriations from the General Fund;

(b) pool policy premium payments; and

(c) all interest and dividends earned on the pool fund's assets.

(3) All money received by the pool fund shall be deposited in compliance with Section 51-4-1 and shall be held by the state treasurer and invested in accordance with Title 51, Chapter 7, State Money Management Act.

(4) The pool fund shall comply with the accounting policies, procedures, and reporting requirements established by the Division of Finance.

(5) The pool fund shall comply with Title 63A, Utah Administrative Services Code.

(6) Beginning July 1, 2015, the pool fund is subject to Chapter 30, Part 4, Small Employer Premium Rebate Program.

Section 12. Section **31A-30-103** is amended to read:

31A-30-103. Definitions.

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with Sections 31A-30-106 and 31A-30-106.1, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.

(4) (a) "Bona fide employer association" means an association of employers:

(i) that meets the requirements of Subsection 31A-22-701(2)(b);

(ii) in which the employers of the association, either directly or indirectly, exercise control over the plan;

(iii) that is organized:

(A) based on a commonality of interest between the employers and their employees that participate in the plan by some common economic or representation interest or genuine organizational relationship unrelated to the provision of benefits; and

(B) to act in the best interests of its employers to provide benefits for the employer's employees and their spouses and dependents, and other benefits relating to employment; and

(iv) whose association sponsored health plan complies with 45 C.F.R. 146.121.

(b) The commissioner shall consider the following with regard to determining whether an association of employers is a bona fide employer association under Subsection (4)(a):

(i) how association members are solicited;

(ii) who participates in the association;

(iii) the process by which the association was formed;

(iv) the purposes for which the association was formed, and what, if any, were the pre-existing relationships of its members;

(v) the powers, rights and privileges of employer members; and

(vi) who actually controls and directs the activities and operations of the benefit programs.

(5) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" do not include:

(i) duration of coverage since the policy was issued;

(ii) claim experience; and

(iii) health status.

(7) "Class of business" means all or a separate grouping of covered insureds that is permitted by the commissioner in accordance with Section 31A-30-105.

(8) "Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

(9) "Covered carrier" means any individual carrier or small employer carrier subject to this chapter.

(10) "Covered individual" means any individual who is covered under a health benefit plan subject to this chapter.

(11) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

(12) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) Chapter 22, Part 6, Accident and Health Insurance.

(13) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

(14) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

(16) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

(17) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit products that are individual policies.

(18) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.

(19) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(20) "Premium" means money paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

(21) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

(22) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.

(23) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the date the plan became effective.

(24) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

[~~(25) "Uninsurable" means an individual who:~~]

[~~(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(5); or~~]

[~~(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and~~]

[~~(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(g) and (h) for which coverage the applicant is applying.~~]

[~~(26) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:~~]

[~~(a) "CI" means the carrier's individual coverage count as of December 31 of the preceding year; and~~]

[~~(b) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997.~~]

Section 13. Section **31A-30-108** is amended to read:

31A-30-108. Eligibility for small employer and individual market.

(1) (a) [~~Small employer carriers shall accept residents~~] A small employer carrier shall accept a small employer that applies for small group coverage as set forth in the Health Insurance Portability and Accountability Act, Sec. 2701(f) and 2711(a) and PPACA, Sec. 2702.

[~~(b) Individual carriers shall accept residents for individual coverage pursuant to:~~]

[~~(i) Health Insurance Portability and Accountability Act, Sec. 2741(a)-(b); and~~]

[~~(ii) Subsection (3).~~]

(b) An individual carrier shall accept an individual that applies for individual coverage as set forth in PPACA, Sec. 2702.

(2) (a) [~~Small~~] A small employer [~~carriers~~] carrier shall offer to accept all eligible employees and their dependents at the same level of benefits under any health benefit plan provided to a small employer.

(b) [~~Small~~] A small employer [~~carriers~~] carrier may:

(i) request a small employer to submit a copy of the small employer's quarterly income tax withholdings to determine whether the employees for whom coverage is provided or requested are bona fide employees of the small employer; and

(ii) deny or terminate coverage if the small employer refuses to provide documentation requested under Subsection (2)(b)(i).

[~~(3) Except as provided in Subsections (5) and (6) and Section 31A-30-110, individual carriers shall accept for coverage individuals to whom all of the following conditions apply:~~]

[~~(a) the individual is not covered or eligible for coverage:~~]

[~~(i) (A) as an employee of an employer;~~]

[~~(B) as a member of an association; or~~]

[~~(C) as a member of any other group; and~~]

[~~(ii) under:~~]

[~~(A) a health benefit plan; or~~]

[~~(B) a self-insured arrangement that provides coverage similar to that provided by a health benefit plan as defined in Section 31A-1-301;~~]

[~~(b) the individual is not covered and is not eligible for coverage under any public health benefits arrangement including:~~]

[~~(i) the Medicare program established under Title XVIII of the Social Security Act;~~]

[~~(ii) any act of Congress or law of this or any other state that provides benefits~~

~~comparable t~~]o the benefits provided under this chapter; or

[~~(iii) coverage under the Comprehensive Health Insurance Pool Act created in Chapter 29, Comprehensive Health Insurance Pool Act;~~]

[~~(c) unless the maximum benefit has been reached the individual is not covered or eligible for coverage under any:~~]

[~~(i) Medicare supplement policy;~~]

[~~(ii) conversion option;~~]

[~~(iii) continuation or extension under COBRA; or~~]

[~~(iv) state extension;~~]

[~~(d) the individual has not terminated or declined coverage described in Subsection (3)(a), (b), or (c) within 93 days of application for coverage, unless the individual is eligible for individual coverage under Health Insurance Portability and Accountability Act, Sec. 2741(b), in which case, the requirement of this Subsection (3)(d) does not apply; and~~]

[~~(e) the individual is certified as ineligible for the Health Insurance Pool if:~~]

[~~(i) the individual applies for coverage with the Comprehensive Health Insurance Pool within 30 days after being rejected or refused coverage by the covered carrier and reapplies for coverage with that covered carrier within 30 days after the date of issuance of a certificate under Subsection 31A-29-111(5)(c); or~~]

[~~(ii) the individual applies for coverage with any individual carrier within 45 days after:~~]

[~~(A) notice of cancellation of coverage under Subsection 31A-29-115(1); or~~]

[~~(B) the date of issuance of a certificate under Subsection 31A-29-111(5)(c) if the individual applied first for coverage with the Comprehensive Health Insurance Pool.~~]

[~~(4) (a) If coverage is obtained under Subsection (3)(e)(i) and the required premium is paid, the effective date of coverage shall be the first day of the month following the individual's submission of a completed insurance application to that covered carrier.~~]

[~~(b) If coverage is obtained under Subsection (3)(e)(ii) and the required premium is paid, the effective date of coverage shall be the day following the:~~]

[~~(i) cancellation of coverage under Subsection 31A-29-115(1); or~~]

[~~(ii) submission of a completed insurance application to the Comprehensive Health Insurance Pool~~].

[~~(5) (a) An individual carrier is not required to accept individuals for coverage under Subsection (3) if the carrier issues no new individual policies in the state after July 1, 1997.~~]

[~~(b) A carrier described in Subsection (5)(a) may not issue new individual policies in the state for five years from July 1, 1997.~~]

[~~(c) Notwithstanding Subsection (5)(b), a carrier may request permission to issue new policies after July 1, 1999, which may only be granted if:~~]

[~~(i) the carrier accepts uninsurables as is required of a carrier entering the market under Subsection 31A-30-110; and~~]

[~~(ii) the commissioner finds that the carrier's issuance of new individual policies:~~]

[~~(A) is in the best interests of the state; and~~]

[~~(B) does not provide an unfair advantage to the carrier.~~]

[~~(6) (a) If the Comprehensive Health Insurance Pool, as set forth under Chapter 29, Comprehensive Health Insurance Pool Act, is dissolved or discontinued, or if enrollment is capped or suspended, an individual carrier may decline to accept individuals applying for individual enrollment, other than individuals applying for coverage as set forth in Health Insurance Portability and Accountability Act, Sec. 2741 (a)-(b).~~]

[~~(b) Within two calendar days of taking action under Subsection (6)(a), an individual carrier will provide written notice to the department.~~]

[~~(7) (a) If a small employer carrier offers health benefit plans to small employers through a network plan, the small employer carrier may:~~]

[~~(i) limit the employers that may apply for the coverage to those employers with eligible employees who live, reside, or work in the service area for the network plan; and~~]

[~~(ii) within the service area of the network plan, deny coverage to an employer if the small employer carrier has demonstrated to the commissioner that the small employer carrier:~~]

[~~(A) will not have the capacity to deliver services adequately to enrollees of any additional groups because of the small employer carrier's obligations to existing group contract holders and enrollees; and~~]

[~~(B) applies this section uniformly to all employers without regard to:~~]

[~~(I) the claims experience of an employer, an employer's employee, or a dependent of an employee; or~~]

[~~(II) any health status-related factor relating to an employee or dependent of an~~

~~employee~~].

[~~(b) (i) A small employer carrier that denies a health benefit product to an employer in any service area in accordance with this section may not offer coverage in the small employer market within the service area to any employer for a period of 180 days after the date the coverage is denied.~~]

[~~(ii) This Subsection (7)(b) does not:~~]

[~~(A) limit the small employer carrier's ability to renew coverage that is in force; or~~]

[~~(B) relieve the small employer carrier of the responsibility to renew coverage that is in force.~~]

[~~(c) Coverage offered within a service area after the 180-day period specified in Subsection (7)(b) is subject to the requirements of this section.~~]

Section 14. Section **31A-30-301** is enacted to read:

Part 3. Individual and Small Employer Risk Adjustment Act

31A-30-301. Title.

This part is known as the Individual and Small Employer Risk Adjustment Act.

Section 15. Section **31A-30-302** is enacted to read:

31A-30-302. Creation of state risk adjustment program.

(1) The commissioner shall convene a group of stakeholders and actuaries to assist the commissioner with the evaluation or the risk adjustment options described in Subsection (2). If the commissioner determines that a state-based risk adjustment program is in the best interest of the state, the commissioner shall establish an individual and small employer market risk adjustment program in accordance with 42 U.S.C. 18063 and this section.

(2) The risk adjustment program adopted by the commissioner may include one of the following models:

(a) continue the United States Department of Health and Human Services administration of the federal model for risk adjustment for the individual and small employer market in the state;

(b) have the state administer the federal model for risk adjustment for the individual and small employer market in the state;

(c) establish and operate a state based risk adjustment program for the individual and small employer market in the state; or

(d) another risk adjustment model developed by the commissioner under Subsection (1).

(3) Before adopting one of the models described in Subsection (2), the commissioner:

(a) may enter into contracts to carry out the services needed to evaluate and establish one of the risk adjustment options described in Subsection (2); and

(b) shall, prior to October 30, 2014, comply with the reporting requirements of Section 63M-1-2505.5 regarding the commissioner's evaluation of the risk adjustment options described in Subsection (2).

(4) The commissioner may:

(a) adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act that require an insurer that is subject to the state based risk adjustment program to submit data to the All Payers Claims Database created under Section 26-33a-106.1; and

(b) establish fees in accordance with Title 63J, Chapter 1, Budgetary Procedures Act to cover the ongoing administrative cost of running the state based risk adjustment program.

Section 16. Section **31A-30-303** is enacted to read:

31A-30-303. Enterprise fund.

(1) There is created an enterprise fund known as the Individual and Small Employer Risk Adjustment Enterprise Fund.

(2) The following funds shall be credited to the pool fund:

(a) appropriations from the General Fund;

(b) fees established by the commissioner under Section 31A-30-302;

(c) risk adjustment payments received from insurers participating in the risk adjustment program; and

(d) all interest and dividends earned on the fund's assets.

(3) All money received by the fund shall be deposited in compliance with Section 51-4-1 and shall be held by the state treasurer and invested in accordance with Title 51, Chapter 7, State Money Management Act.

(4) The fund shall comply with the accounting policies, procedures, and reporting requirements established by the Division of Finance.

(5) The fund shall comply with Title 63A, Utah Administrative Services Code.

(6) The fund shall be used to implement and operate the risk adjustment program created by this part.

Section 17. Section **31A-30-401** is enacted to read:

Part 4. Small Employer Premium Rebate Program

31A-30-401. Title.

This chapter is known as the "Small Employer Premium Rebate Program."

Section 18. Section **31A-30-402** is enacted to read:

31A-30-402. Definitions.

For purposes of this part:

(1) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:

(a) works at least 30 hours per calendar week; and

(b) meets employer eligibility waiting requirements for health care insurance which may not exceed the first day of the calendar month following 60 days from the date of hire.

(2) "Minimum essential coverage" means:

(a) a qualified health plan offered on the small employer health exchange or in the small employer non-exchange market; and

(b) a renewed plan that is not a qualified health plan, but is recognized as a compliant plan under the transition policies issued by the Center for Consumer Information and Insurance Oversight within the Centers for Medicare and Medicaid Services in the United States Department of Health and Human Services.

Section 19. Section **31A-30-403** is enacted to read:

31A-30-403. Small employer premium rebate.

Beginning in taxable year 2014 and continuing through taxable year 2017, and to the extent a premium rebate in the amount designated in Section 31A-30-404 is available, a small employer may receive a premium rebate if:

(1) the small employer's principle place of business is domiciled in Utah;

(2) the small employer offers minimum essential coverage to an employee at a minimum of 75% of the calendar days during the taxable year in which the small employer applies for the premium rebate;

(3) the small employer pays at least 50% of the premium cost of employee only

coverage during the taxable year; and

(4) the small employer submits proof of coverage and premium payment to the commissioner in the form, manner and time required by the commissioner by administrative rule adopted in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

Section 20. Section **31A-30-404** is enacted to read:

31A-30-404. Calculation of small employer rebate.

(1) Each taxable year, the commissioner shall, by administrative rule adopted in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, develop a formula to calculate the amount of the taxable year's rebate for a small employer who submits a request for rebate under Section 31A-30-403.

(2) The formula developed under Subsection (1) shall limit the total rebates paid to all small employers in a taxable year to the funds available in that taxable year in the Small Employer Rebate Program Enterprise Fund established in Section 31A-30-405.

Section 21. Section **31A-30-405** is enacted to read:

31A-30-405. Small Employer Rebate Enterprise Fund.

(1) There is created an enterprise fund known as the Small Employer Rebate Enterprise Fund.

(2) The following funds shall be credited to the pool fund:

(a) appropriations from the General Fund;

(b) beginning July 1, 2015, any funds remaining in the Comprehensive Health Insurance Pool Enterprise Fund created in Section 31A-29-120; and

(c) all interest and dividends earned on the fund's assets.

(3) All money received by the fund shall be deposited in compliance with Section 51-4-1 and shall be held by the state treasurer and invested in accordance with Title 51, Chapter 7, State Money Management Act.

(4) The fund shall comply with the accounting policies, procedures, and reporting requirements established by the Division of Finance.

(5) The fund shall comply with Title 63A, Utah Administrative Services Code.

(6) The funds shall be used to pay the small employer rebates in accordance with Section 31A-30-404 and to pay the cost of administering the rebate program established by this part.

Section 22. Section **63A-5-205** is amended to read:

63A-5-205. Contracting powers of director -- Retainage -- Health insurance coverage.

(1) As used in this section:

(a) "Capital developments" has the same meaning as provided in Section 63A-5-104.

(b) "Capital improvements" has the same meaning as provided in Section 63A-5-104.

(c) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of hire.

(d) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

(e) "Qualified health insurance coverage" is as defined in Section 26-40-115.

(f) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) In accordance with Title 63G, Chapter 6a, Utah Procurement Code, the director may:

(a) subject to Subsection (3), enter into contracts for any work or professional services which the division or the State Building Board may do or have done; and

(b) as a condition of any contract for architectural or engineering services, prohibit the architect or engineer from retaining a sales or agent engineer for the necessary design work.

(3) (a) Except as provided in Subsection (3)(b), this Subsection (3) applies to all design or construction contracts entered into by the division or the State Building Board on or after July 1, 2009, and:

(i) applies to a prime contractor if the prime contract is in the amount of $1,500,000 or greater; and

(ii) applies to a subcontractor if the subcontract is in the amount of $750,000 or greater.

(b) This Subsection (3) does not apply:

(i) if the application of this Subsection (3) jeopardizes the receipt of federal funds;

(ii) if the contract is a sole source contract;

(iii) if the contract is an emergency procurement; or

(iv) to a change order as defined in Section 63G-6a-103, or a modification to a contract, when the contract does not meet the threshold required by Subsection (3)(a).

(c) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (3)(a) is guilty of an infraction.

(d) (i) A contractor subject to Subsection (3)(a) shall demonstrate to the director that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents.

(ii) If a subcontractor of the contractor is subject to Subsection (3)(a), the contractor shall demonstrate to the director that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents.

(e) (i) (A) A contractor who fails to meet the requirements of Subsection (3)(d)(i) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (3)(f).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (3)(d)(ii).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (3)(d)(ii) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (3)(f).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (3)(d)(i).

(f) The division shall adopt administrative rules:

(i) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(ii) in coordination with:

(A) the Department of Environmental Quality in accordance with Section 19-1-206;

(B) the Department of Natural Resources in accordance with Section 79-2-404;

(C) a public transit district in accordance with Section 17B-2a-818.5;

(D) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(E) the Department of Transportation in accordance with Section 72-6-107.5; and

(F) the Legislature's Administrative Rules Review Committee; and

(iii) which establish:

(A) the requirements and procedures a contractor must follow to demonstrate to the director compliance with this Subsection (3) which shall include:

(I) that a contractor will not have to demonstrate compliance with Subsection (3)(d)(i) or (ii) more than twice in any 12-month period; and

(II) that the actuarially equivalent determination required for the qualified health insurance coverage in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(Aa) the Utah Insurance Department;

(Bb) an actuary selected by the contractor or the contractor's insurer; or

(Cc) an underwriter who is responsible for developing the employer group's premium rates;

(B) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this Subsection (3), which may include:

(I) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(II) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(III) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(IV) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and the dependents of an employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract; and

(C) a website on which the department shall post the benchmark for the qualified health insurance coverage identified in Subsection (1)(e).

(g) (i) In addition to the penalties imposed under Subsection (3)(f)(iii), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (3)(g)(i) if:

(A) the employer relied in good faith on a written statement of actuarial equivalency provided by:

(I) an actuary; or

(II) an underwriter who is responsible for developing the employer group's premium rates; or

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3)(b).

(iii) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (3)(g).

(h) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created by Section 26-18-402.

(i) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(i) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(ii) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

(4) The judgment of the director as to the responsibility and qualifications of a bidder is conclusive, except in case of fraud or bad faith.

(5) The division shall make all payments to the contractor for completed work in accordance with the contract and pay the interest specified in the contract on any payments that are late.

(6) If any payment on a contract with a private contractor to do work for the division or the State Building Board is retained or withheld, it shall be retained or withheld and released as provided in Section 13-8-5.

Section 23. Section **63C-9-403** is amended to read:

63C-9-403. Contracting power of executive director -- Health insurance coverage.

(1) For purposes of this section:

(a) "Employee" means an "employee," "worker," or "operative" as defined in Section

34A-2-104 who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first of the calendar month following [~~90~~] 60 days from the date of hire.

(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

(c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) (a) Except as provided in Subsection (3), this section applies to a design or construction contract entered into by the board or on behalf of the board on or after July 1, 2009, and to a prime contractor or a subcontractor in accordance with Subsection (2)(b).

(b) (i) A prime contractor is subject to this section if the prime contract is in the amount of $1,500,000 or greater.

(ii) A subcontractor is subject to this section if a subcontract is in the amount of $750,000 or greater.

(3) This section does not apply if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section 63G-6a-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

(b) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (2) is guilty of an infraction.

(5) (a) A contractor subject to Subsection (2) shall demonstrate to the executive director that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents during the duration of the contract.

(b) If a subcontractor of the contractor is subject to Subsection (2)(b), the contractor shall demonstrate to the executive director that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the contract.

(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the division under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) the State Building Board in accordance with Section 63A-5-205;

(iv) a public transit district in accordance with Section 17B-2a-818.5;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate to the executive director compliance with this section which shall include:

(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or (b) more than twice in any 12-month period; and

(B) that the actuarially equivalent determination required for the qualified health insurance coverage in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(I) the Utah Insurance Department;

(II) an actuary selected by the contractor or the contractor's insurer; or

(III) an underwriter who is responsible for developing the employer group's premium rates;

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for employees and dependents of employees of the contractor or subcontractor who were not offered qualified health insurance coverage during the duration of the contract; and

(iii) a website on which the department shall post the benchmark for the qualified health insurance coverage identified in Subsection (1)(c).

(7) (a) (i) In addition to the penalties imposed under Subsection (6)(c), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if:

(A) the employer relied in good faith on a written statement of actuarial equivalency provided by:

(I) an actuary; or

(II) an underwriter who is responsible for developing the employer group's premium rates; or

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3) or (4).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 24. Section **63I-1-231 (Effective 07/01/14)** is amended to read:

63I-1-231 (Effective 07/01/14). Repeal dates, Title 31A.

(1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2015.

(2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2023.

(3) Section 31A-22-619.6, Coordination of benefits with workers' compensation claim--Health insurer's duty to pay, is repealed on July 1, 2018.

(4) Chapter 29, Comprehensive Health Insurance Pool Act, is repealed July 1, 2015.

Section 25. Section **63I-1-263** is amended to read:

63I-1-263. Repeal dates, Titles 63A to 63M.

(1) Section 63A-4-204, authorizing the Risk Management Fund to provide coverage to any public school district which chooses to participate, is repealed July 1, 2016.

(2) Subsections 63A-5-104(4)(d) and (e) are repealed on July 1, 2014.

(3) Section 63A-5-603, State Facility Energy Efficiency Fund, is repealed July 1, 2016.

(4) Title 63C, Chapter 4a, Constitutional and Federalism Defense Act, is repealed July 1, 2018.

(5) Section 53B-24-402, rural residency training program, is repealed July 1, 2015.

(6) Title 63C, Chapter 13, Prison Relocation and Development Authority Act, is repealed July 1, 2014.

(7) Title 63C, Chapter 14, Federal Funds Commission, is repealed July 1, 2018.

(8) Subsection 63G-6a-1402(7) authorizing certain transportation agencies to award a contract for a design-build transportation project in certain circumstances, is repealed July 1, 2015.

(9) Title 63H, Chapter 4, Heber Valley Historic Railroad Authority, is repealed July 1,

2020.

(10) The Resource Development Coordinating Committee, created in Section 63J-4-501, is repealed July 1, 2015.

(11) Title 63M, Chapter 1, Part 4, Enterprise Zone Act, is repealed July 1, 2018.

(12) (a) Title 63M, Chapter 1, Part 11, Recycling Market Development Zone Act, is repealed January 1, 2021.

(b) Subject to Subsection (12)(c), Sections 59-7-610 and 59-10-1007 regarding tax credits for certain persons in recycling market development zones, are repealed for taxable years beginning on or after January 1, 2021.

(c) A person may not claim a tax credit under Section 59-7-610 or 59-10-1007:

(i) for the purchase price of machinery or equipment described in Section 59-7-610 or 59-10-1007, if the machinery or equipment is purchased on or after January 1, 2021; or

(ii) for an expenditure described in Subsection 59-7-610(1)(b) or 59-10-1007(1)(b), if the expenditure is made on or after January 1, 2021.

(d) Notwithstanding Subsections (12)(b) and (c), a person may carry forward a tax credit in accordance with Section 59-7-610 or 59-10-1007 if:

(i) the person is entitled to a tax credit under Section 59-7-610 or 59-10-1007; and

(ii) (A) for the purchase price of machinery or equipment described in Section 59-7-610 or 59-10-1007, the machinery or equipment is purchased on or before December 31, 2020; or

(B) for an expenditure described in Subsection 59-7-610(1)(b) or 59-10-1007(1)(b), the expenditure is made on or before December 31, 2020.

(13) [~~(a)~~] Section 63M-1-2507, Health Care Compact is repealed on July 1, [~~2014~~] 2019.

[~~(b) (i) The Legislature shall, before reauthorizing the Health Care Compact:~~]

[~~(A) direct the Health System Reform Task Force to evaluate the issues listed in Subsection (13)(b)(ii), and by January 1, 2013, develop and recommend criteria for the Legislature to use to negotiate the terms of the Health Care Compact; and~~]

[~~(B) prior to July 1, 2014, seek amendments to the Health Care Compact among the member states that the Legislature determines are appropriate after considering the recommendations of the Health System Reform Task Force.~~]

[~~(ii) The Health System Reform Task Force shall evaluate and develop criteria for the Legislature regarding:~~]

[~~(A) the impact of the Supreme Court ruling on the Affordable Care Act;~~]

[~~(B) whether Utah is likely to be required to implement any part of the Affordable Care Act prior to negotiating the compact with the federal government, such as Medicaid expansion in 2014;~~]

[~~(C) whether the compact's current funding formula, based on adjusted 2010 state expenditures, is the best formula for Utah and other state compact members to use for establishing the block grants from the federal government;~~]

[~~(D) whether the compact's calculation of current year inflation adjustment factor, without consideration of the regional medical inflation rate in the current year, is adequate to protect the state from increased costs associated with administering a state based Medicaid and a state based Medicare program;~~]

[~~(E) whether the state has the flexibility it needs under the compact to implement and fund state based initiatives, or whether the compact requires uniformity across member states that does not benefit Utah;~~]

[~~(F) whether the state has the option under the compact to refuse to take over the federal Medicare program~~];

[~~(G) whether a state based Medicare program would provide better benefits to the elderly and disabled citizens of the state than a federally run Medicare program;~~]

[~~(H) whether the state has the infrastructure necessary to implement and administer a better state based Medicare program;~~]

[~~(I) whether the compact appropriately delegates policy decisions between the legislative and executive branches of government regarding the development and implementation of the compact with other states and the federal government; and~~]

[~~(J) the impact on public health activities, including communicable disease surveillance and epidemiology.~~]

(14) The Crime Victim Reparations and Assistance Board, created in Section 63M-7-504, is repealed July 1, 2017.

(15) Title 63M, Chapter 11, Utah Commission on Aging, is repealed July 1, 2017.

Section 26. Section **63M-1-2504** is amended to read:

63M-1-2504. Creation of Office of Consumer Health Services -- Duties.

(1) There is created within the Governor's Office of Economic Development the Office of Consumer Health Services.

(2) The office shall:

(a) in cooperation with the Insurance Department, the Department of Health, and the Department of Workforce Services, and in accordance with the electronic standards developed under Sections 31A-22-635 and 63M-1-2506, create a Health Insurance Exchange that:

(i) provides information to consumers about private and public health programs for which the consumer may qualify;

(ii) provides a consumer comparison of and enrollment in a health benefit plan posted on the Health Insurance Exchange; and

(iii) includes information and a link to enrollment in premium assistance programs and other government assistance programs;

(b) contract with one or more private vendors for:

(i) administration of the enrollment process on the Health Insurance Exchange, including establishing a mechanism for consumers to compare health benefit plan features on the exchange and filter the plans based on consumer preferences;

(ii) the collection of health insurance premium payments made for a single policy by multiple payers, including the policyholder, one or more employers of one or more individuals covered by the policy, government programs, and others; and

(iii) establishing a call center in accordance with Subsection (3);

(c) assist employers with a free or low cost method for establishing mechanisms for the purchase of health insurance by employees using pre-tax dollars;

(d) establish a list on the Health Insurance Exchange of insurance producers who, in accordance with Section 31A-30-209, are appointed producers for the Health Insurance Exchange; [~~and~~]

(e) submit, before November 1, an annual written report to the Business and Labor Interim Committee and the Health System Reform Task Force regarding the operations of the Health Insurance Exchange required by this chapter[~~.~~]; and

(f) assist a small employer with submitting a form that provides proof that the small employer provided health insurance to its qualified employees in a taxable year, if that form:

(i) is required by the Internal Revenue Service for the small employer to apply for a federal tax credit; or

(ii) is required for a small employer to apply for a state premium rebate under Title 31A, Chapter 30, Part 4, Small Employer Premium Rebate Program.

(3) A call center established by the office:

(a) shall provide unbiased answers to questions concerning exchange operations, and plan information, to the extent the plan information is posted on the exchange by the insurer; and

(b) may not:

(i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;

(ii) receive producer compensation through the Health Insurance Exchange; and

(iii) be designated as the default producer for an employer group that enters the Health Insurance Exchange without a producer.

(4) The office:

(a) may not:

(i) regulate health insurers, health insurance plans, health insurance producers, or health insurance premiums charged in the exchange;

(ii) adopt administrative rules, except as provided in Section 63M-1-2506; or

(iii) act as an appeals entity for resolving disputes between a health insurer and an insured;

(b) may establish and collect a fee for the cost of the exchange transaction in accordance with Section 63J-1-504 for:

(i) processing an application for a health benefit plan;

(ii) accepting, processing, and submitting multiple premium payment sources;

(iii) providing a mechanism for consumers to filter and compare health benefit plans in the exchange based on consumer preferences; and

(iv) funding the call center; and

(c) shall separately itemize the fee established under Subsection (4)(b) as part of the cost displayed for the employer selecting coverage on the exchange.

Section 27. Section **63M-1-2507** is amended to read:

63M-1-2507. The Health Care Compact.

The Health Care Compact is hereby enacted and entered into with all other jurisdictions that legally join in the compact, which is, in form, substantially as follows:

Health Care Compact

Whereas, the separation of powers, both between the branches of the federal government and between federal and state authority, is essential to the preservation of individual liberty;

Whereas, the Constitution creates a federal government of limited and enumerated powers, and reserves to the states or to the people those powers not granted to the federal government;

Whereas, the federal government has enacted many laws that have preempted state laws with respect to health care, and placed increasing strain on state budgets, impairing other responsibilities such as education, infrastructure, and public safety;

Whereas, the member states seek to protect individual liberty and personal control over health care decisions, and believe the best method to achieve these ends is by vesting regulatory authority over health care in the states;

Whereas, by acting in concert, the member states may express and inspire confidence in the ability of each member state to govern health care effectively; and

Whereas, the member states recognize that consent of Congress may be more easily secured if the member states collectively seek consent through an interstate compact;

NOW THEREFORE, the member states hereto resolve, and by the adoption into law under their respective state constitutions of this health care compact, agree, as follows:

Sec. 1. Definitions.

As used in this compact, unless the context clearly indicates otherwise:

(1) "Commission" means the Interstate Advisory Health Care Commission.

(2) "Effective date" means the date upon which this compact shall become effective for purposes of the operation of state and federal law in a member state, which shall be the later of:

(a) the date upon which this compact shall be adopted under the laws of the member state, and

(b) the date upon which this compact receives the consent of Congress pursuant to Article I, Section 10, of the United States Constitution, after at least two member states adopt this compact.

(3) "Health care" means care, services, supplies, or plans related to the health of an individual and includes but is not limited to:

(a) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care and counseling, service, assessment, or procedure with respect to the physical or mental condition or functional status of an individual or that affects the structure or function of the body, and

(b) sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription, and

(c) an individual or group plan that provides, or pays the cost of, care, services, or supplies related to the health of an individual, except any care, services, supplies, or plans provided by the United States Department of Defense and United States Department of Veteran Affairs, or provided to Native Americans.

(4) "Member state" means a state that is signatory to this compact and has adopted it under the laws of that state.

(5) "Member state base funding level" means a number equal to the total federal spending on health care in the member state during federal fiscal year 2010. On or before the effective date, each member state shall determine the member state base funding level for its state, and that number shall be binding upon that member state. The preliminary estimate of member state base funding level for the state of Utah is $4,102,000,000.

(6) "Member state current year funding level" means the member state base funding level multiplied by the member state current year population adjustment factor multiplied by the current year inflation adjustment factor.

(7) "Member state current year population adjustment factor" means the average population of the member state in the current year less the average population of the member state in federal fiscal year 2010, divided by the average population of the member state in federal fiscal year 2010, plus 1. Average population in a member state shall be determined by the United States Census Bureau.

(8) "Current year inflation adjustment factor" means the total gross domestic product deflator in the current year divided by the total gross domestic product deflator in federal fiscal year 2010. Total gross domestic product deflator shall be determined by the Bureau of Economic Analysis of the United States Department of Commerce.

Sec. 2. Pledge.

The member states shall take joint and separate action to secure the consent of the United States Congress to this compact in order to return the authority to regulate health care to the member states consistent with the goals and principles articulated in this compact. The member states shall improve health care policy within their respective jurisdictions and according to the judgment and discretion of each member state.

Sec. 3. Legislative Power.

The legislatures of the member states have the primary responsibility to regulate health care in their respective states.

Sec. 4. State Control.

Each member state, within its state, may suspend by legislation the operation of all federal laws, rules, regulations, and orders regarding health care that are inconsistent with the laws and regulations adopted by the member state pursuant to this compact. Federal and state laws, rules, regulations, and orders regarding health care will remain in effect unless a member state expressly suspends them pursuant to its authority under this compact. For any federal law, rule, regulation, or order that remains in effect in a member state after the effective date, that member state shall be responsible for the associated funding obligations in its state.

Sec. 5. Funding.

(a) Each federal fiscal year, each member state shall have the right to federal monies up to an amount equal to its member state current year funding level for that federal fiscal year, funded by Congress as mandatory spending and not subject to annual appropriation, to support the exercise of member state authority under this compact. This funding shall not be conditional on any action of or regulation, policy, law, or rule being adopted by the member state.

(b) By the start of each federal fiscal year, Congress shall establish an initial member state current year funding level for each member state, based upon reasonable estimates. The final member state current year funding level shall be calculated, and funding shall be reconciled by the United States Congress based upon information provided by each member state and audited by the United States Government Accountability Office.

Sec. 6. Interstate Advisory Health Care Commission.

(a) The Interstate Advisory Health Care Commission is established. The commission

consists of members appointed by each member state through a process to be determined by each member state. A member state may not appoint more than two members to the commission and may withdraw membership from the commission at any time. Each commission member is entitled to one vote. The commission shall not act unless a majority of the members are present, and no action shall be binding unless approved by a majority of the commission's total membership.

(b) The commission may elect from among its membership a chairperson. The commission may adopt and publish bylaws and policies that are not inconsistent with this compact. The commission shall meet at least once a year, and may meet more frequently.

(c) The commission may study issues of health care regulation that are of particular concern to the member states. The commission may make non-binding recommendations to the member states. The legislatures of the member states may consider these recommendations in determining the appropriate health care policies in their respective states.

(d) The commission shall collect information and data to assist the member states in their regulation of health care, including assessing the performance of various state health care programs and compiling information on the prices of health care. The commission shall make this information and data available to the legislatures of the member states. Notwithstanding any other provision in this compact, no member state shall disclose to the commission the health information of any individual, nor shall the commission disclose the health information of any individual.

(e) The commission shall be funded by the member states as agreed to by the member states. The commission shall have the responsibilities and duties as may be conferred upon it by subsequent action of the respective legislatures of the member states in accordance with the terms of this compact.

(f) The commission shall not take any action within a member state that contravenes any state law of that member state.

Sec. 7. Congressional Consent.

This compact shall be effective on its adoption by at least two member states and consent of the United States Congress. This compact shall be effective unless the United States Congress, in consenting to this compact, alters the fundamental purposes of this compact, which are:

(a) to secure the right of the member states to regulate health care in their respective states pursuant to this compact and to suspend the operation of any conflicting federal laws, rules, regulations, and orders within their states; and

(b) to secure federal funding for member states that choose to invoke their authority under this compact, as prescribed by Section 5 of this compact.

Sec. 8. Amendments.

The member states, by unanimous agreement, may amend this compact from time to time without the prior consent or approval of Congress and any amendment shall be effective unless, within one year, the Congress disapproves that amendment. Any state may join this compact after the date on which Congress consents to the compact by adoption into law under its state constitution.

Sec. 9. Withdrawal; Dissolution.

Any member state may withdraw from this compact by adopting a law to that effect, but no such withdrawal shall take effect until six months after the governor of the withdrawing member state has given notice of the withdrawal to the other member states. A withdrawing state shall be liable for any obligations that it may have incurred prior to the date on which its withdrawal becomes effective. This compact shall be dissolved upon the withdrawal of all but one of the member states.

Sec. 10. Sunset.

This compact sunsets [~~on July 1, 2014~~] in accordance with Section 63I-1-263.

Section 28. Section **72-6-107.5** is amended to read:

72-6-107.5. Construction of improvements of highway -- Contracts -- Health insurance coverage.

(1) For purposes of this section:

(a) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of hire.

(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

(c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) (a) Except as provided in Subsection (3), this section applies to contracts entered into by the department on or after July 1, 2009, for construction or design of highways and to a prime contractor or to a subcontractor in accordance with Subsection (2)(b).

(b) (i) A prime contractor is subject to this section if the prime contract is in the amount of $1,500,000 or greater.

(ii) A subcontractor is subject to this section if a subcontract is in the amount of $750,000 or greater.

(3) This section does not apply if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract is a sole source contract; or

(c) the contract is an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section 63G-6a-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

(b) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (2) is guilty of an infraction.

(5) (a) A contractor subject to Subsection (2) shall demonstrate to the department that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents during the duration of the contract.

(b) If a subcontractor of the contractor is subject to Subsection (2), the contractor shall demonstrate to the department that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the contract.

(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during

the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) the Department of Natural Resources in accordance with Section 79-2-404;

(iii) the State Building Board in accordance with Section 63A-5-205;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) a public transit district in accordance with Section 17B-2a-818.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate to the department compliance with this section which shall include:

(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or (b) more than twice in any 12-month period; and

(B) that the actuarially equivalent determination required for qualified health insurance coverage in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(I) the Utah Insurance Department;

(II) an actuary selected by the contractor or the contractor's insurer; or

(III) an underwriter who is responsible for developing the employer group's premium rates;

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and a dependent of the employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract; and

(iii) a website on which the department shall post the benchmark for the qualified health insurance coverage identified in Subsection (1)(c).

(7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if:

(A) the employer relied in good faith on a written statement of actuarial equivalency provided by:

(I) an actuary; or

(II) an underwriter who is responsible for developing the employer group's premium rates; or

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3) or (4).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or

contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 29. Section **79-2-404** is amended to read:

79-2-404. Contracting powers of department -- Health insurance coverage.

(1) For purposes of this section:

(a) "Employee" means an "employee," "worker," or "operative" as defined in Section 34A-2-104 who:

(i) works at least 30 hours per calendar week; and

(ii) meets employer eligibility waiting requirements for health care insurance which may not exceed the first day of the calendar month following [~~90~~] 60 days from the date of hire.

(b) "Health benefit plan" has the same meaning as provided in Section 31A-1-301.

(c) "Qualified health insurance coverage" is as defined in Section 26-40-115.

(d) "Subcontractor" has the same meaning provided for in Section 63A-5-208.

(2) (a) Except as provided in Subsection (3), this section applies a design or construction contract entered into by, or delegated to, the department or a division, board, or council of the department on or after July 1, 2009, and to a prime contractor or to a subcontractor in accordance with Subsection (2)(b).

(b) (i) A prime contractor is subject to this section if the prime contract is in the amount of $1,500,000 or greater.

(ii) A subcontractor is subject to this section if a subcontract is in the amount of $750,000 or greater.

(3) This section does not apply to contracts entered into by the department or a division, board, or council of the department if:

(a) the application of this section jeopardizes the receipt of federal funds;

(b) the contract or agreement is between:

(i) the department or a division, board, or council of the department; and

(ii) (A) another agency of the state;

(B) the federal government;

(C) another state;

(D) an interstate agency;

(E) a political subdivision of this state; or

(F) a political subdivision of another state; or

(c) the contract or agreement is:

(i) for the purpose of disbursing grants or loans authorized by statute;

(ii) a sole source contract; or

(iii) an emergency procurement.

(4) (a) This section does not apply to a change order as defined in Section 63G-6a-103, or a modification to a contract, when the contract does not meet the initial threshold required by Subsection (2).

(b) A person who intentionally uses change orders or contract modifications to circumvent the requirements of Subsection (2) is guilty of an infraction.

(5) (a) A contractor subject to Subsection (2)(b)(i) shall demonstrate to the department that the contractor has and will maintain an offer of qualified health insurance coverage for the contractor's employees and the employees' dependents during the duration of the contract.

(b) If a subcontractor of the contractor is subject to Subsection (2)(b)(ii), the contractor shall demonstrate to the department that the subcontractor has and will maintain an offer of qualified health insurance coverage for the subcontractor's employees and the employees' dependents during the duration of the contract.

(c) (i) (A) A contractor who fails to meet the requirements of Subsection (5)(a) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A contractor is not subject to penalties for the failure of a subcontractor to meet the requirements of Subsection (5)(b).

(ii) (A) A subcontractor who fails to meet the requirements of Subsection (5)(b) during the duration of the contract is subject to penalties in accordance with administrative rules adopted by the department under Subsection (6).

(B) A subcontractor is not subject to penalties for the failure of a contractor to meet the requirements of Subsection (5)(a).

(6) The department shall adopt administrative rules:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(b) in coordination with:

(i) the Department of Environmental Quality in accordance with Section 19-1-206;

(ii) a public transit district in accordance with Section 17B-2a-818.5;

(iii) the State Building Board in accordance with Section 63A-5-205;

(iv) the State Capitol Preservation Board in accordance with Section 63C-9-403;

(v) the Department of Transportation in accordance with Section 72-6-107.5; and

(vi) the Legislature's Administrative Rules Review Committee; and

(c) which establish:

(i) the requirements and procedures a contractor must follow to demonstrate compliance with this section to the department which shall include:

(A) that a contractor will not have to demonstrate compliance with Subsection (5)(a) or (b) more than twice in any 12-month period; and

(B) that the actuarially equivalent determination required for qualified health insurance coverage in Subsection (1) is met by the contractor if the contractor provides the department or division with a written statement of actuarial equivalency from either:

(I) the Utah Insurance Department;

(II) an actuary selected by the contractor or the contractor's insurer; or

(III) an underwriter who is responsible for developing the employer group's premium rates;

(ii) the penalties that may be imposed if a contractor or subcontractor intentionally violates the provisions of this section, which may include:

(A) a three-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the first violation;

(B) a six-month suspension of the contractor or subcontractor from entering into future contracts with the state upon the second violation;

(C) an action for debarment of the contractor or subcontractor in accordance with Section 63G-6a-904 upon the third or subsequent violation; and

(D) monetary penalties which may not exceed 50% of the amount necessary to purchase qualified health insurance coverage for an employee and a dependent of an employee of the contractor or subcontractor who was not offered qualified health insurance coverage during the duration of the contract; and

(iii) a website on which the department shall post the benchmark for the qualified

health insurance coverage identified in Subsection (1)(c).

(7) (a) (i) In addition to the penalties imposed under Subsection (6), a contractor or subcontractor who intentionally violates the provisions of this section shall be liable to the employee for health care costs that would have been covered by qualified health insurance coverage.

(ii) An employer has an affirmative defense to a cause of action under Subsection (7)(a)(i) if:

(A) the employer relied in good faith on a written statement of actuarial equivalency provided by:

(I) an actuary; or

(II) an underwriter who is responsible for developing the employer group's premium rates; or

(B) the department determines that compliance with this section is not required under the provisions of Subsection (3) or (4).

(b) An employee has a private right of action only against the employee's employer to enforce the provisions of this Subsection (7).

(8) Any penalties imposed and collected under this section shall be deposited into the Medicaid Restricted Account created in Section 26-18-402.

(9) The failure of a contractor or subcontractor to provide qualified health insurance coverage as required by this section:

(a) may not be the basis for a protest or other action from a prospective bidder, offeror, or contractor under Section 63G-6a-1603 or any other provision in Title 63G, Chapter 6a, Utah Procurement Code; and

(b) may not be used by the procurement entity or a prospective bidder, offeror, or contractor as a basis for any action or suit that would suspend, disrupt, or terminate the design or construction.

Section 30. **Repealer.**

This bill repeals:

Section **31A-29-111, Eligibility -- Limitations.**

Section **31A-29-112, Medicaid recipients.**

Section **31A-29-115, Cancellation -- Notice.**

Section **31A-29-116, Notice of availability.**

Section **31A-29-117, Premium rates.**